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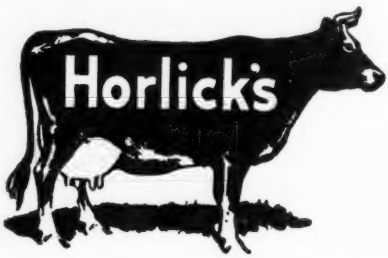

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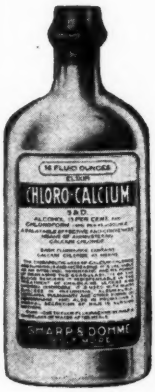

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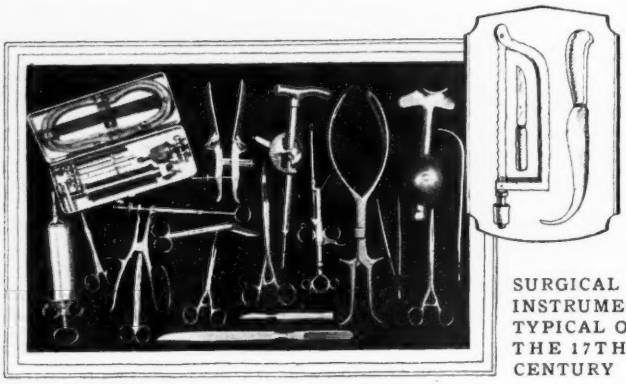

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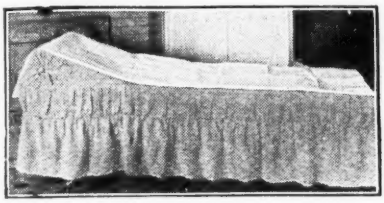

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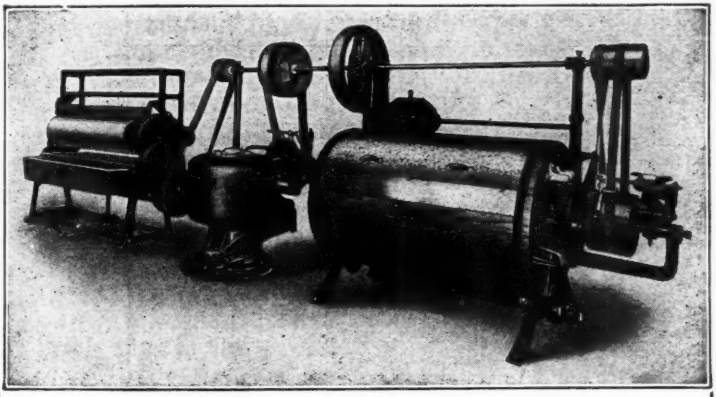

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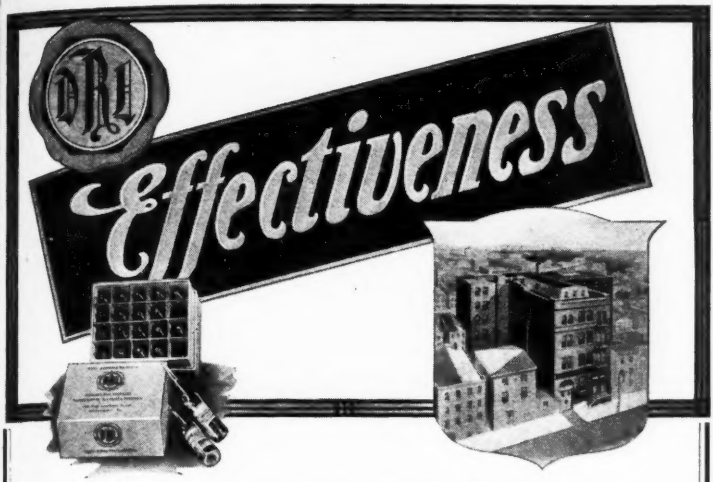

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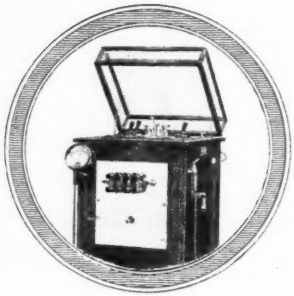

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Volume II | JUNE, 1924 | Number 9

Editorial

VACATIONS

THE winter has been a long one in the northern states and spring has been late in many sections. We're just beginning to think of the vacation season here and our thoughts turn to the woods and the streams, where the only noises are the chorus of the birds, the camper's call, and the rippling of the brook.

We feel an inward urge to get far from the smoky city, the traffic cops and the cliff dwellers' apartments.

We love our work, but we would get back to nature now and then to rest our tired nerves, to quietly inventory ourselves and get a new grip on the essential things of life.

A change of environment is the best medicine for jangled nerves and ragged tempers.

We want to drop our lines in the dark pools under the overhanging trees. We crave the thrill of tracking game and coming back to camp with an honest, outdoor, appetite again.

MRS. H. C. PHIBBS

Too much are we indoors—too little do we see of nature at her best.

Those evenings around the camp fire are a pleasant mem-

"BILL" CAMERON AND HIS DOG

ory. Our work is behind us and we roll into our blankets tired and early for a solid ten hour sleep.

In the woods have we renewed our pep, quieted our fears for the future and built up our resistance against another year of strenuous work.

The woods are nature's shock-absorbers for tired business men and women.

Physicians and hospital workers are particularly benefited by a few weeks of quiet relaxation and rest. They need and deserve a good vacation.

Two good friends of The Hospital Buyer who believe in getting back to nature are pictured here. The good-looking and athletic lady is Mrs. Harry C. Phibbs, whose husband is writing a wonderfully interesting series of articles for this magazine. He also contributes to "Hygeia" and other magazines. Both Mr. and Mrs. Phibbs are ardent lovers of outdoors, and spend their spare time in the woods and open spaces of the Indiana dunes. Mrs. Phibbs is a crack shot with the rifle, an adept in the canoe and an experienced camper.

The woodsman snapped by Mr. Phibbs is no other than our friend "Bill" Cameron, organizer and president of Cameron's Surgical Specialty Company, Chicago, accompanied by his favorite dog. Mr. Cameron is one of the hardest workers we know of. He concentrates on business and loves it just as he does to hunt the moose and shoot wild ducks in the Canadian wilds. We understand he will head that way this fall with Harry Phibbs—a great pair to draw to.

So get out your guide books, your maps and your vacation togs. Plan your trip early and get away from work for a few weeks for your health's sake.

A. M. A. MEETING A SUCCESS

THE Seventy-fifth annual session of the American Medical Association, held in Chicago, June 9th to 12th, was one of the most successful in the history of that organization. The total registration was in excess of eight thousand; 6,970 were registered for the first three days. The feature of this meeting was the unique location, the Municipal Pier. It was found that this was an ideal location for the general sessions, section meetings and exhibits, all being gathered under one roof.

The Scientific Exhibit was especially noteworthy and great interest was displayed in the Commercial Exhibits. Among the advertisers in The Hospital Buyer who were represented among the exhibits were The Acme-International X-Ray Co., Chicago; Frank S. Betz Co., Hammond, Ind.; Dashell Labo-

ratories, Chicago; J. A. Deknatel & Sons, Brooklyn; The De Vilbiss Mfg. Co., Toledo; Earnshaw Sales Co., Chicago; H. G. Fischer & Co., Chicago; Hoffmann-La Roche Chemical Co., New York; Johnson Ventlite Co., Chicago; Eli Lilly & Co., Indianapolis; Medical Protective Co., Fort Wayne, Ind.; Mellin's Food Co., Boston; Toledo Technical Appliance Co., Toledo, Ohio, and The Abbott Laboratories, Chicago.

Mr. Will C. Braun deserves great credit as the Director of Exhibits, the best in the history of the association.

The report of the Committee on Awards for the Scientific Exhibit is as follows:

Report of Committee on Awards

Scientific Exhibit

The Committee on Awards reports:

The gold medal to E. J. Judah, Mayo Clinic, because of (a) originality, (b) method of presentation of museum specimens, and (c) completeness of the exhibit demonstrating thoroughly the pathology of gallbladder disease.

The silver medal to W. W. Duke, Kansas City, because of the completeness of the exhibit on "allergy."

The bronze medal to Benjamin Terry, Nashville, for the effort involved in his personal demonstration of pathologic material carrying a message to the mass of physicians.

The committee also awards the certificate of merit to the following:

Evarts Graham, Warren H. Cole and Grover H. Copher of the Washington University Medical School of St. Louis, Mo., for visualization of the gallbladder.

Indiana Child Hygiene Division, Board of Health, for exhibit of child health activities.

Ralph Major, University of Kansas, for study of effect of methylguanidin on blood pressure.

Northwestern University for exhibit of museum specimens illustrating important lesions of (a) heart and blood vessels, (b) gastro-intestinal tract, (c) kidney, (d) the female sexual organs.

Section on Dermatology and Syphilology of the University of Pennsylvania for the excellency of the photographic reproductions.

The committee desires to commend the general arrangement, neatness, lighting and freedom from confusion of the scientific exhibit, and recommends it as a model for future exhibits. The committee has been particularly impressed by the fact that there have been competent demonstrators in charge of the respective exhibits and that the legends have been well printed, making the exhibits more valuable to the visitors.

The committee appreciated the work of the two special committees, the committee on cardiology and the committee on morbid anatomy. It feels that these features (which were not open to awards) deserve special praise. The committee would like to see these exhibits of morbid anatomy and pathology continue.

The director of the scientific exhibit, Dr. Paul N. Leech, acting for the committee of the Board of Trustees, deserves unstinted praise from the committee for the part he has played in the general excellence of the exhibit.

Urban Maes, Chairman
James Ewing
Roger S. Morris

Office of Skin Specialist, Kobe, Japan

Office of Venereal Disease Specialist
Kyoto, Japan

Midwife's Office,
Kyoto, Japan

Medical Practitioners and Pharmacists in Japan

By E. AHLSWEDE, Tokyo, Japan

Special to THE HOSPITAL BUYER

THE general impression of a visit to some twenty hospitals in various towns of Japan, including the university clinics of Tokyo, several private hospitals in Kyoto, Kobe, Yokohama, also a visit to several offices of general practitioners and specialists at Kobe, Kyoto, etc., may be roughly summed up in the following:

The equipment and apparatus are on the whole below the American or European standard—in some instances the instrumentarium is even primitive. On the other hand, the average Japanese doctor is very well educated—like most of his countrymen, he is mentally alert, a quick thinker and knows his matter. He has a good library and his general and special knowledge form a strange contrast to the poor apparatus he is frequently obliged to work with.

This condition is chiefly due to the inefficient production of medical instruments and apparatus in Japan itself, while the high cost of importation from America or Europe bring many instruments out of the reach of the average practitioner.

Nor is the government itself financially in a position to equip even its university clinics and laboratories with more than the absolute necessities.

As already stated, the theoretical training of the medical practitioner is thorough. A medical practitioner in Japan must study medicine in a university coming under the Universities Ordinance and acquire the title of gakushi, or he must complete the medical course in a special medical college, government, public, or designated by the Minister of Education.

The total number of medical practitioners at the end of 1919 was 45,426, at the rate of one practitioner for every 1,234 of the population of the country, or eight practitioners for every 10,000 inhabitants.

Dental Surgeons, Pharmacists, Midwives and Nurses

A dental surgeon in Japan has to complete the course in a special dental college designated by the minister of education, or pass the examination for dental surgeons, or complete the course in a foreign dental school and obtain a license from the Minister of Home Affairs.

The total number of dental surgeons at the end of 1919 in Japan was 5,336, besides six foreign dental surgeons.

A pharmacist in Japan must possess the diploma of the pharmaceutical course in the medical department of the medical college of an Imperial University. The total number of pharmacists in Japan at the end of 1919 was 7,714, at the rate of one pharmacist for every six medical practitioners.

Midwives—A midwife has to complete the course in a school or training institute designated by the Minister for Home Affairs. She must be entered in the midwives' register in charge of the local governor.

Dentist's Office, Kyoto, Japan

The total number of midwives in Japan at the end of 1919 was 35,235, at the rate of 6.2 midwives for every 10,000 of the population.

Nurses—A nurse in Japan has to pass the examination for nurses or complete the course in a school or training institute designated by the local governor, and must obtain a license from him.

The total number of nurses at the end of 1919 was 35,520.

Acupuncturists, Moxicauterists and Shampooers

Persons engaged in acupuncture, moxicautery, and shampooing must pass an examination or complete the course in schools or training institutes designated by local governors and obtain licenses from them.

The total number of these persons in Japan in 1919 was 69,080, of which 10,117 practiced both acupuncture and moxicautery.

HYGIENE AND SANITARY STATISTICS

IN 1916 a Council for the Investigation of Health Preservation and Hygiene was established in Tokyo. Two years later a special staff was appointed to take charge of matters relating to these investigations.

Since then considerable progress has been made relating to national health-preservation and hygiene. Several laws and accommodations have been made public. The most important of these are: the law for the prevention of tuberculosis and the law concerning asylums for the insane, accommodations to encourage the stamping out of parasitical diseases and malaria fever and the establishment of the institute for the study of alimentation as an instrument for solving the food question.

Important investigations were also made for the purpose of preventing and stamping out venereal diseases and leprosy, as well as practical investigation of rural and urban hygiene.

Especially with regard to rural hygiene a very large number of villages were examined on the spot and are still under examination.

Sanitary Statistics

The first step in sanitary statistics was taken in Japan in 1876, when statistics were made from materials regarding births and deaths collected from the prefectures.

Three years later a form of statistics was decided upon with respect to tables of sufferers from infections, local and other diseases, and various other matters relating to hygiene. After local reports had been made the results of the work of sanitation in the whole country were

(*Continued on page 56*)

American College of Surgeons Meeting Discusses Important Hospital Problems

By C. L. Neu

Special to The Hospital Buyer

HOSPITAL standardization was the subject discussed at a round table conference of the New York State section of the American College of Surgeons at a recent meeting in Albany. While the subject of records was not discussed as a separate question, it entered incidentally into each problem as it came up. This department considers that a number of valuable and interesting points were brought out and that readers of these columns will be interested in the report of what happened.

Staff Meetings. Who shall attend these meetings? This question was considered from various angles and it was agreed by the majority that the meeting should be attended by the Staff, the Internes and the Superintendent. It was suggested that the Historian should attend and this brought out various opinions, some holding that the historian should attend and others that she had no place in meetings of this kind. A logical conclusion was reached by one of the speakers when he said that an historian should be carefully selected, that she should have a serious interest in her work and that if she was of this character she undoubtedly should take her place at the Staff Meetings, not with a view to entering into the discussions, but simply to get the point-of-view of the hospital and its executives.

Another important point regarding Staff Meetings had to do with rules and regulations covering this matter. It was advocated that definite rules be decided upon and that they be put up in printed form. These rules should cover such points as the obligation to attend consultations when requested, the order of business, subjects for discussion, etc.

Consultation. Supposing a patient asks the Superintendent to arrange for a consultation regarding the case and that the physician whose patient has asked for the consultation has not acquiesced. What is the position of the Superintendent? On this question some held that it was a matter to be decided by the patient and the physician. Others held that the hospital endeavoring to give the best kind of service should bring every influence to bear to get the patient what he wants. One definite point was settled and that was that the matter of consultations should be accurately defined in the book of rules covering Staff procedure.

Nomenclature and Classifications. In the interests of accurate records, how is it to be decided whether a patient left the hospital cured, improved or not improved? Some held that the

terms are inaccurate and for statistical purposes they are practically worthless. Supposing, for instance, that a diphtheria case entered the hospital and while the patient was in the institution a cardiac condition developed. The patient's condition when he left the hospital showed no improvement, while he was definitely cured of the original complaint, diphtheria. How are the records to show what actually happened?

Probably the best suggestion made was that several classifications should be maintained, such as primary, secondary and so on. In the case referred to above the primary condition, diphtheria, should be recorded as "cured." Secondary condition should be recorded as "not improved." Such a method as this makes for accurate records and statistics based on such records will be of some value.

The International Classification was pointed out as being the most complete one to be found.

Laboratory Fees. According to the speakers there were four methods of covering the laboratory charges in the hospital. They are as follows:

(1) Schedule of Fees.
(2) Flat rate.
(3) Endowed or State support.
(4) Inclusive or Concealed.

The Schedule of Fees is used in a large number of hospitals and it is plain to the reader that this is a list of the various examinations, different amounts being charged for each kind of examination which the case required. The charges for these examinations are added to the hospital bill to the patient.

Under the Flat Rate method the patient is charged so much for laboratory work when he enters the hospital. It is a charge based upon the average cost as shown by the figures covering a period. Some Superintendents favor this method.

In some institutions the laboratory receives endowed or state support and there is no definite charge against the patient.

The Inclusive or Concealed method of handling laboratory charges is gaining favor. The plan is this: The hospital figures out that the average laboratory cost per patient per week comes to a certain amount and this amount is added to the charge for the room or ward. In this way laboratory fees are paid by the patient when he pays for his accommodations, and it is not made a separate item.

The method last described overcomes many of the difficulties and questions regarding charges. Under the schedule of fees method there is always some discussion as to the charges made, and in many cases the accounts cannot be collected. If the laboratory work is included in the accommodation charge there is no further discussion.

Autopsies. The question of autopsies confronts every institution. How to get relatives or friends to consent to autopsies is a difficult matter. One Superintendent explained that the benefit to be derived from autopsies was so well instilled in the minds of the internes that they were enthusiastic about convincing the near relatives or friends that such a procedure should be followed. Of course, religious and sentimental prejudices make it difficult to obtain permission in many cases. Those in attendance at this meeting reported from 3% to

(*Continued on page 49*)

THE DRYING TUMBLER

THERE are certain classes of work in the hospital laundry which must be tumbled to bring about the best results in the finished product. Such items, as blankets, bath towels, bath robes and so on, should be tumbled dry. This action resulting in a soft, fluffy finish. Ironing such pieces is not desirable, because it produces a harsh result not at all comfortable to the user. The tumbling and air circulation in the machine results in the loosening of the fibres and thorough aeration.

In the small hospital laundry where steam is not available, gas or electricity is used for heating ironers, and these ironers, of course, are of the smaller sizes. Under these conditions the work must be pre-dried before ironed in order to accomplish any quantity of work. In the past, a drying cabinet has been necessary, causing, of course, a great deal of labor, as each must be handled individually. Now, there is a small gas or electric heated tumbler, entirely satisfactory for the small hospital up to 80 or 100 beds, and the same well finished product is possible in the smaller hospitals. When a tumbler is used the work is simply taken from the extractor and put in the tumbler in large lots, the machine closed and the tumbler begins to work. Later it is only necessary to unload, which means a great saving in labor over the dry-room method.

Under some conditions it may be necessary even to pre-dry the work in the larger hospital laundry before doing the ironing, possibly because the ironing equipment does not keep up. By pre-drying for ten or fifteen minutes in the tumbler the ironers and pressers can be speeded up and more work produced without enlarging the finishing equipment.

The proper tumbling of the clothes improves the finished work, making ironing easier and having the effect of eliminating any odors of washing material, such as bleach or sour, which may not be rinsed out in the washing process. If your tumbler is built to permit the air being circulated through the clothes and coils more than once, do not use this feature, but draw in a continuous supply of clean, pure air, pass it through the clothes and discharge. One passage through the clothes will saturate the air sufficiently with moisture to make it worth while to discharge and replace with fresh air. By this method thorough circulation is assured and clean, sweet-smelling clothes will result.

Any disadvantages which may be encountered in the use of a drying tumbler more often than not are the fault of operation, than actual inefficiency on the part of the average drying tumbler. There are several points to watch for in tumbling clothes, as mentioned; be sure to keep a constant circulation of fresh air flowing through the machine. Using the same air over and over is not satisfactory.

Watch carefully the load in the tumbler and take it out when it is dry, but not bone-dry. Tumbling the clothes in the tumbler after they really should be taken out causes overheating and breaking up of the fibres, resulting in too much lint and excessive wear and tear on the clothes.

In general, then, cut down the heat in the tumbler and remove the clothes at the proper time. With these few hints you can get the utmost from your drying tumbler and completely eliminate the possible disadvantages.

NEWS OF PHILADELPHIA AND VICINITY

Special to THE HOSPITAL BUYER

UNDER the will of Mrs. Fanny W. Stout, Philadelphia, the Presbyterian Hospital of that city is left a fund of $10,000 for establishing a free room. The gift is in the nature of a memorial to Mrs. Stout's husband, George H. Stout, who for 55 years was a teacher in the public schools.

The Locust Mountain Hospital, erected by public subscription, at Shenandoah Heights, Locust Mountain, overlooking the city of Shenandoah, at a cost of more than $350,000, has been accepted. The hospital contains one hundred beds and is known as one of the finest buildings of its kind in the State. Dr. John C. Gallagher, of Shenandoah, is surgeon-in-chief.

Mayor Kendrick, on June 10, signed a contract with W. V. Pangborne Company, for electrical work in three new cottage buildings at the Institution for the Feeble Minded, and in three new dormitories at the Hospital for the Insane, at Byberry. The cost is $104,998.75. The Mayor also signed a contract with Nicholas Connolly, for installing plumbing and drainage systems in the new structures mentioned, at a cost of $93,459.

At the annual meeting of contributors to Chester County Hospital, West Chester, the following members of the board of managers whose terms had expired, were re-elected to serve for the coming three years: Mrs. Thomas Parke, Downingtown; Charles R. Hoopes, Dr. William T. Sharpless and Samuel Marshall, all of West Chester. The receipts for the hospital for the year past amounted to more than $105,000. The indebtedness has been increased.

WHAT BOOK DO YOU RECOMMEND?

THE HOSPITAL BUYER.

Gentlemen:

I have just come into possession of your May edition and I find it absorbingly interesting. I am part buyer and part accountant for the above institution and will appreciate any information you can give me on both.

I would like to have your complete accounting forms at your earliest convenience as we are just now installing a revised system, and I think from Mr. Neu's lucid explanation it is just what is wanted for correct and complete records.

If you know of a good text on institutions, please let me know how I can get it.

THOMAS QUINN,
Decatur and Macon County Hospital and School of Nursing,
Decatur, Illinois.

METEOROLOGY IN GENERAL

What is it molds the life of man?
The weather.
What makes some black and others tan?
The weather.
What makes the Zulus live in trees
And Congo natives dress in leaves?
The weather.
—Scientific Monthly.

The Layman's Viewpoint on Hospital Diet

By HARRY C. PHIBBS

The Second of a Series of Unusual Articles on Hospital Topics Written by an Observing Layman

(*Written Especially for* HOSPITAL BUYER)

THE food they give the patient in the hospital always reminds me of the story of the man who went into a restaurant and asked to see the proprietor—and was told that the proprietor had gone out to lunch!

Every time I eat a meal in a hospital, a sanitarium or similar institution, I have had grave doubts as to whether the dietitian inflicted the same food on her own palate.

I say "palate" advisedly, because not for worlds would I dare insinuate that the collection of proteins, carbohydrates, fats, vitamins, et cetera, would offend that human fuel box, the stomach. Nor do I know enough about diet as a scientific proposition to say that it is not in line with the best food that the stomach should have. Being a layman, when I talk of food I think of palate.

Hospital diet always smacks of the institution. It is carefully measured out, weighed, considered from the point of nutrition and cost—and as diet it may rank very high, but as food it is something to make the ghost of Lucullus weep. It is "institution fare." So, no doubt, is the food they give prisoners—a dab of this and a slice of that and a slab of the other thing, all thrown together, higglety-pigglety, on a couple of plates and set down in front of you to eat as a duty, for it could not be a pleasure.

Cod-liver oil, doubtless, is wonderful nourishment, but, my goodness, who would want to take it as his only diet?

Hotels become famous and make a great deal of money because of the excellence of their cooking. High-priced chefs study ways in which to tickle the palate of the patron—and food, to be regular food, should tickle the palate first. Food must tickle the palate before it gets into the mouth. It must be cooked and served and garnished in such a way that as soon as the eye perceives it you get that delightful tickling sensation in the palate.

The person who is sick is naturally finicky. The patient in a hospital is a great deal more in need of finicky touches on food than the healthy, husky individual who goes into the Hotel de Pazazza to have the artistic contributions of a French chef make him smack his lips in anticipation as soon as the cover is lifted from the plate.

Oh, you dietitians! Were I a rich man with a lot of money, I could have a lot of fun with you. I could take you, one by one, and bring you out to some real caravanserie and set you down and have two meals served on the one table—one, a meal prepared and calculated by a dietitian who is nothing else but; the other, the same meats, the same vegetables, the same amount of food, having

the same caloric value, but prepared by a chef who knew his business, and I would dare you to eat your own cooking in preference!

If such a thing were possible as a hospital in which the food was so tempting and so appetizing that every patient who left that hospital, instead of recounting the particulars of his operation, told glowing tales of the wonderful food that was served — that hospital would have so much reputation, so many patients, so much good will, and so many contributions, that it would rapidly become the most famous hospital in America.

Now, I am merely a layman. I have eaten food in one of the most famous sanitariums in the world, and the food tasted like so much sawdust! I was told that it had so many calories, that it was so rich in this and so good for that — and every time that meal time came around, instead of feeling like the doughboy who hollers "When do we eat?" I always felt, with a sinking of the anticipatory organs, "Gosh! Do we have to eat again?"

The dietitian is prone to regard food too much as fuel. The sensation which we get from the appetite appeal and the activity of the salivary glands in the mouth must have something to do with the digestion of our food—and if food has not that appetite appeal, it cannot be as good as food which has it.

Isn't it the eye which, looking on a tempting dish, first starts the saliva flowing; and doesn't this in turn start the gastric juice flowing; and didn't Mother Nature provide this as a means of helping the human organism to properly digest and assimilate its food? Isn't it true that when the food starts in the mouth with the proper flow of saliva and gastric juice, it gets the correct impetus through the digestive process; and when the food gets this correct impetus, isn't that when the body gets its best nourishment from the food?

So, friend dietitian, do not stick up your scientific nose and sniff at the art of the chef, for this art, allied to your science, would make a wonderful combination.

With all this, friend dietitian, don't you think that after you have completed your course in dietetics you should take the finishing touch of a course in fancy cooking—or, if you will, gastronomics? In other words, a dietitian, to be a good dietitian, should also be a chef.

If there is a hospital in the country where the dietitian is so much of a chef that she could get a job running the kitchen in a first class hotel, I would like to know where that hospital is, and when any of my friends are sick I will send them to it—and might be coaxed to put up there myself for a visit, just to enjoy the quiet, the peace, the solitude of hospitalization, the care, the nursing, and the FOOD!

NEW YORK PROTECTS THE PUBLIC

A regulation recently passed in Greater New York specifies that every man or woman handling food for the public must obtain a license from the department of health certifying that he or she is free from contagious or infectious disease.

It is estimated that about 180,000 persons will require licenses.

Electricity for Cooking

By T. L. DRIMMIE

An Interesting and Valuable Article Setting Forth the Relative Values and Costs of Coal, Gas and Electricity

FOR the hospital, electricity as a fuel is of great advantage. No flue being necessary, electricity can be used in any part of the building for ward, kitchen, or other purposes without incurring any great expense for installation.

The lasting qualities of electric ranges and bake ovens exceed that of any other kind. The finished product is better, and the tendency in the near future will, doubtless, be that as the coal and gas equipments wear out, electrical apparatus will replace them wherever the cost of current permits.

The experimental days are over. Heating units are now practically indestructible. Apparatus suitable for the heaviest duty is standard and obtainable in large quantities and enough installations have been running long enough to eliminate any doubt of their efficiency and durability under the most severe conditions.

The above figures do not include the labor involved in the care of coal fires, nor maintenance on either coal, gas, or electric fixtures—neither is the labor required in the preparation of meals considered.

The coal fire is never of uniform heat, the heat varying with the condition of the fire. The continuous use of the hot fire necessary in large establishments very soon burns out the grates and linings, and cracks the tops, necessitating replacements at comparatively short intervals. Carrying in the coal and carrying out the ashes need extra labor and cause dust to be diffused over the kitchen.

Burners on gas fixtures need constant adjustments and cleaning in order to maintain the maximum efficiency. A large percentage of the heat is carried away by the flues which must be provided to carry off the products of combustion. Besides the heat is diffused

ELECTRIC KITCHEN COSTS

	Coal at $14.00 per ton	Gas at $1.80 cu. ft.	Electricity 2 cents per K. W. H.
Unit	Pound	Cubic Ft.	K. W. H.
Cost per unit	0.007	.001	.02
B. T. U. per unit	14,000	550	3413
Efficiency	6.5%	15%	80%
Useful B. T. U. per unit	910	82.5	2730
B. T. U. per person per meal	700	700	700
Cost of fuel per person per meal	.0054	.0085	.0057
Useful B. T. U. for one cent	1300	820	1230

in the kitchen to a great extent. The draft in the ovens also dries up the roasts to a greater extent.

The modern electrical appliances require very little maintenance—80 percent of the heat generated actually goes into the cooking. Flexibility of control enables the amount of heat used to be kept at the minimum necessary for the work. Another important point is they can be used where there is no flue at all.

The insulation of the oven in the electric range enables less current to be used and from the even heat preserves the juices in the meat, thus increasing the weight of the roasted meat over any other form of oven.

In an actual test recently conducted, two identical rib roasts of pork cut from opposite sides of the same pig and weighing the same were put, the one in an electric range oven, and the other in a gas range oven—the door of the electric oven was not opened once during the cooking—by the cook in charge—while the cook in charge of the gas oven opened the oven door frequently to baste and examine the roast. When the cook in charge of the gas oven reported his roast done, the cook in charge of the electric oven took his roast out. The two roasts were then weighed and it was found that the one cooked by gas had lost 28 percent while the one cooked by electricity had only lost 6 percent in the cooking. This test showed conclusively that the insulated oven, maintained at an even temperature with no loss of heat by opening the door frequently, or by radiation, and having no draft to dry up the roast, kept the juices in the meat instead of evaporating them and saved a larger percentage of the roast for use than the gas range was able to do.

The most important item of equipment in the kitchen and the one where the most fuel is consumed is of course the range and it is all important that this be built according to specifications which insure its standing up under the heavy duty imposed upon it in a large establishment. It may be required to stay at a dull red heat for eighteen hours out of twenty-four supporting kettles, weighing hundreds of pounds, the upsetting of one of which may deluge it with liquid. The range, however, to be practical must stand up under just such usage.

The following is a specification which will give a range calculated to give the best results both in practicability and durability.

Specifications for Electric Range.

Body to be constructed of not less than 16 gauge black sheet steel securely riveted or welded at all joints, riveted to a steel framework of not less than 1½"x1½"x⅛" angle steel.

The oven should be not less than 21" wide and 28" deep by 16" in height. The oven should be securely riveted to the range body and supported in the rear by 1½"x1½"x⅛" angle iron which should in turn be riveted to the range frame.

The oven casing should be of not less than 16 gauge black steel and the lining of not less than 16 gauge black Armco iron (or equal). The surfaces of these parts should be given a coat of black heat resisting enamel or of something equally protective as a protection against rust before the range is assembled. The space between the oven casing and lining should be packed with the best heat insulating material obtainable, the distance between casing and lining being not less than three inches. A steel rack constructed of not less than ⅛" thick supported on suitable rack slides should be provided for the oven.

A Modern Electric Cooking Unit

The oven door should be of the drop type mounted on the range by spring hinges so that the weight is balanced when opened 45 degrees. The door frame should be of not less than ¼"x1½" steel all parts welded together to form an integral frame. The door body should be constructed of not less than 18 gauge sheet steel. The space between the back shell and door front shall be filled with rock wool insulation not less than 1½ inches thick. A vertical steel latch bar should be provided to hold the door securely in the closed position. All door support castings must be capable of supporting a weight of 1,000 lbs. placed at the outer edge of the door when open without injurious effects.

The heating units should be as follows: Top—four 9"x24" cast in type hot plates each with a maximum energy consumption of 4,000 Watts. The top surface around the units should be made of 10 gauge steel polished and securely bolted to the top of frame work. Oven—two 3 K W ele-

ments one placed on the oven bottom and the other supported close to the oven top. These units should be securely held in place by catches which will permit their easy and quick removal. The bottom unit should be protected by a perforated casting.

A range built to these specifications should be capable of supporting a load of one thousand pounds continuously while hot without buckling or warping.

The question of switches is a very important one because of the liability to overheating if they are placed on the range instead of being mounted on a steel box installed away from the heat of the range which is seldom convenient.

Each heating unit should be controlled by a three heat snap switch. When mounted on the range these switches should be on the front of the range on one side of the oven on a removable panel. Each unit should be protected by two cartridge fuses, one in each side of the line. The fuse panel should be mounted below the switchpan. Bus bars and terminal connectors should be provided for connection between the line and the fuse blocks.

The space behind the switch and fuse compartments should be constructed with a flue connection to insure removal of heat from the switches and fuses, or some other provision made to insure a draft of cold air passing over the fuses and switches. This portion of the range should be protected against radiated heat from the surface-plates by means of heat insulating pads made so as to be easily removable.

A scavenger pan should be provided under the cooking surface arranged to catch all drippings and so installed as to be easily removable. The size of range should be about as follows: Height 34 inches, length 48 inches, depth 39 inches. The range body can be constructed to pass through a 30 inch door if so specified.

The range can be surmounted by a plate warmer and if desired a broiler can also be installed above it. The maximum consumption of a range of this type would be 16 K W per hour for the top 4 plates and 6 K W per hour for the 2 oven units, making 22 K W per hour were the range worked on full capacity all the time which in practice has not been found necessary.

The time necessary to get the range hot enough to do good cooking is only 20 minutes from cold.

In a test made May 11, 1921, on three electric ranges over 8 hours during which time 3,750 persons were served the actual consumption of current was 272 K W H or 34 K W per hour. Taking 2 cents as the cost of current this test shows an average of 68 cents per hour or $5.44 for the eight hours for the range work for 3,750 people.

The main arguments aside from material and operating costs for electricity are:

1. Cleanliness.
2. Less heat in kitchen.
3. Certainty of operation, because not subject to variations of heat as in coal and the same variations because of varying pressures in gas.
4. Roasts retain the juices to a greater extent and consequently an appreciable percentage of waste is eliminated and they are more palatable.
5. Economy in the actual cost of fuel when properly handled.

With the exception of the steamers, every piece of equipment making up a complete kitchen, is now made heated by electric current, but it is generally agreed that with the exception of ranges, ovens, broilers and toasters, steam heating is best when available.

Probably the most important thing in the kitchen, after the range, is the bake oven, usually located in the bake shop, but often an extra one is installed in the kitchen for the baking of meats, beans, potatoes, and other things, thus saving the fuel in the range 10 gauge steel attached to a heavy, single iron frame with sides of 18 gauge galvanized or other rust-proof metal.

In the most modern type, each compartment is heated by a unit top and bottom, there being no air circulation from the one to the other. The floor of the compartment should be of fire tile, laid on steel supports and cemented so the joints are tight all over. The doors must have fastenings assuring perfectly tight closing.

When build in this way, each baking compartment can have the heat applied to it which its contents demand to produce the best results, and the oven thermometer attached to each compartment enables the operator to regulate each compartment exactly to the temperature desired.

Where ovens are to be used for meats, turkeys, etc., the compartments are made higher than in those to be used entirely for baking bread and pastries.

The advantages of electric ovens which have been proved are these:

1. Better and more uniform quality of product.

2. Lower percentage of the product spoiled during baking.

3. Goods baked electrically retain their freshness for a longer period, thereby reducing losses due to stale product.

4. Saving of one-third to one-half floor space required for a fuel-fired oven.

5. Eliminates the sometimes difficult and expensive problem of providing a furnace chimney.

6. No labor to handle fuel and ashes.

7. Eliminates constant provision for fuel.

8. No dirt or dust from fuel.

9. Can be installed on any floor of a building without bringing up the fuel handling problem.

10. More uniform deck temperature.

11. More accurate and flexible control of temperature.

12. Electrically baked pastry is superior to that baked in any other measure, and failures are unknown.

13. A lower rate of insurance on buildings where electric equipment is used.

The walls of the bake oven being heavily insulated, the oven loses no heat by radiation but retains a baking heat long after the current is shut off. After the oven is brought up to the desired heat by using the full current it is maintained at the necessary heat by using the medium or low heat while the baking is in progress.

The electric oven for baking has been so successful that it is used by practically all the large commercial bakeries all over the country—of course, these ovens are very much larger than those used in kitchens, but the efficiency given by the even temperature maintained applies to the large and small electric ovens alike.

The number of heats the switches are set for, runs from three to six, according to the size of the oven and the voltage used.

The various items of electrical apparatus with their consumptions follow:

Cake griddles usually 18 inches wide by from 18 to 54 inches long have a wattage of 3 K W for each 18 inches in length.

Toasters with a 16 slice capacity with heat elements above and below have a wattage of 3 K W.

(Continued on page 62)

The Scottish Rite Hospital
Atlanta

Special to THE HOSPITAL BUYER

NINE years ago a member of the Atlanta Consistory of Ancient and Accepted Scottish Rite Masons was struck by a railroad train and his leg was seriously crushed and broken.

He was not only a member of the Atlanta Consistory but of Yaarab Temple of the Shrine as well—and when the leg refused to mend under ordinary treatment, Forrest Adair, then Imperial Potentate of the Shrine, sent him to Dr. Michael Hoke—Atlanta's famous surgeon—for treatment.

Dr. Hoke performed several operations—but as the man was financially unable to pay him, he declined to submit any bill for the work. Mr. Adair then asked to be permitted to pay the bill—but Dr. Hoke refused to submit any.

Finally, after Potentate Adair had argued with him on several occasions he submitted a bill for five dollars—and let it go at that.

When Mr. Adair called upon him, Dr. Hoke explained that he frequently performed these operations without compensation. Why, he told Mr. Adair, he could cure a dozen children in Atlanta right at that time if he only had a place in which to put them for treatment. He liked to do the work—he wanted to do more of it if he could.

Potentate Adair went home and thought the matter out—and as a result of that evening

View of the Scottish Rite Hospital, Atlanta

of thinking there developed the Scottish Rite Hospital for Crippled Children in Atlanta—and at least five Shrine Hospitals for Crippled Children in the United States and Canada. And there are more hospitals in the making.

Forrest Adair left Dr. Hoke's office with one fixed idea — to provide the beds somehow so that the crippled children spoken of might be taken care of. He spoke to the Scottish Rite officials about it. He brought it before the next meeting of the Consistory. And as a result in September, 1915, two small cottages on Hill street, in Decatur, near the junction of the South Decatur car line and East Lake Drive, were secured and a hospital of twenty beds opened for the care of crippled children.

The two cottages—makeshift at best — were soon outgrown.

Patients had to be carried into the city for operations and taken back again for convalescence. The twenty beds soon became inadequate to take care of the children waiting to be treated. In June, 1917, the pressure for new and suitable quarters became so great that a drive for funds was begun and $22,000 was collected.

War troubles came on and the work had to be dropped for the time being.

But it was not for long. A public-spirited citizen — Albert Steiner—donated $25,000 toward the building fund. The Scottish Rite body supplemented this with $20,000, raising this later to $40,000. An additional $15,000 was secured from other sources. And in June, 1918, in spite of the high cost of building materials, the board of directors decided to build an adequate hospital.

Plans were drawn up by leading Atlanta architects, the work was started, and in August, 1919, the present building was ready for occupancy.

The final cost of the building was $130,000. The banks are still carrying $30,000 of this cost of construction. But the Scottish Rite Hospital for Crippled Children stands as a model in hospital construction—and has been used as the model for the five Shrine hospitals recently constructed throughout the United States.

In the two-story central portion is a receiving ward, a record room, a reception room, and an office. On the second floor there is a modern and well-equipped operating room—one of the best in the city—an X-ray room, a dental clinic, and a sterilizing room.

On either side of the main building are two one-story hospital units, containing fifty-six beds in all and so arranged that other units can be added later if required.

Everything is of fire-proof brick and stucco construction. Inside the floors are all of tile, the walls clean and pleasantly tinted, the beds and furnishings of spotless white enamel. Outside the grounds are more like those of a park than a hospital.

In the nine years the hospital has been in operation, 1,886 children have undergone treatment in it. There are sixty children in it now—and 160 on the waiting list awaiting their turn for treatment.

And there are still more than 2,000 crippled children in Georgia alone awaiting treatment—and 450,000 crippled children in the United States waiting to be helped by hospitals of this sort.

The average age of the children treated by the hospital is twelve years, but there is no limit one way or the other. Babies two or three years old are taken. Boys and girls fifteen and sixteen years old are

given treatment if, in the estimation of the surgeons, they can be benefited in this manner.

An average of one child a day is taken in by the Scottish Rite Hospital for treatment. An average of one child a day is dismissed as either cured or very materially helped.

In the eight years the hospital has been in operation, only three or four patients have died —and the percentage of cures, due to the magic knife of Dr. Michael Hoke, has been remarkably high.

Club feet, deformed limbs, curvature of the spine, paralysis and atrophy have no terrors for doctors at the Scottish Rite Hospital for Crippled Children. They know how to treat and cure them all.

The arrival at the hospital on the day I visited it had a very bad case of club feet. They will put both of this child's feet into plaster casts to soften them. They will remain in the casts for two weeks. Then they will be gradually wedged back into the proper position. Finally there will be an operation on each foot—a relatively simple operation—and when this heals she will be ready to walk like other children. The feet will be completely straightened out.

For a while she may be compelled to wear braces to give her the required strength to walk—but in a little while these will be discarded. And the entire operation and cure will be made in less than six months.

The average length of time spent by each child in the hospital is only fifty-five days. At the end of that time it is so improved that it can go home and recover with proper treatment, making way for some other little patient. Last year the report shows that 337 operations were performed and 118 deformities corrected at the hospital.

And the average cost was $2.37 each child each day!

The average cost of healing a crippled child at the hospital is only $130—yet for this $130 it gets the best food and attention that money can buy and expert surgery that would cost the ordinary patient at least $1,000.

Yet even at this low cost, the expense of maintaining the hospital averages more than $50,000 a year.

Where does the money come from?

From voluntary contributions altogether. Each Scottish Rite class makes a voluntary contribution toward the hospital. Every year the Atlanta Consistory takes up a collection for its support. Many individuals help.

Every Monday, for example, the employees of the Rogers chain grocery stores in Atlanta take up a collection for the hospital. They contribute from 1 to 25 cents apiece out of none too munificent wages, and in this way raise $25 a week, which is given to the manager to spend for whatever the children need most.

Out of such gifts is the Scottish Rite Hospital supported.

There are only 1,500 members of the Atlanta Consistory—and the wonder is that they can carry on the work at all. Yet, somehow, they manage to raise that $50,000 needed every year. The work must go on.

In 1920 Forrest Adair introduced his famous resolution at the Portland Convention of the Mystic Shrine to the effect that this organization support a hospital for the treatment of crippled children in every great city in the United States.

The motion passed—and with its passage the Shrine changed

almost automatically from a pleasure-loving organization to one of the greatest charitable organizations in the world. Two dollars out of each seven which the Shriner pays for annual dues now goes to the support of the Shrine Hospitals for Crippled Children. More than $1,000,000 a year is being spent by the Shrine in building and maintaining these hospitals.

The first of these — modeled after the Scottish Rite hospital in Atlanta — was completed in 1922 at Shreveport, La. Four others are in operation—in Minneapolis, San Francisco, Portland, Ore., and St. Louis. A sixth hospital at Springfield, Mass., is well under way, and will be completed in October. And sites have been purchased for Shrine hospitals in Montreal, Philadelphia, and Chicago.

An average of $250,000 apiece will be spent on these Shrine hospitals when all are completed. It may take several million dollars a year to maintain them.

But the honor is due to the Scottish Rite Hospital for Crippled Children in Atlanta, which showed the way and provided the inspiration for the great work now being done.

Not long ago a girl was carried to the Scottish Rite Hospital from a North Georgia town. She was fifteen years old and had never been able to stand erect. She didn't walk—she managed to navigate by walking on all four.

Dr. Hoke took her in hand—performed operation after operation with infinite patience—yet always with definite results. She stayed in the hospital eight months. Then she was sent home to convalesce. The hospital had done its work. Other patients demanded its care and attention.

The girl's father went to the train to meet her. The train came in—and pulled out. His child was not on it—it merely left on the platform a young lady whom he did not recognize.

The young lady was the girl who had been sent to the hospital eight months before. She no longer—well—navigated. She walked erect. That father couldn't believe his eyes — he had to see her identification cards before he would believe she was his daughter. That's a fact.

And when the town saw what had happened, every storekeeper in that little Georgia town shut up shop and declared a holiday!

That is the sort of thing the Scottish Rite Hospital for Crippled Children is doing for boys and girls all over Georgia. And that is the way Georgia people are beginning to show their appreciation of the work being done.

With the Shrine hospitals springing up like magic all over the country — with skilled surgeons everywhere ready to give of their time and of their skill—it begins to look as though the day of the crippled child was over. The work which the little Georgia hospital started nine years ago is being carried to a glorious conclusion.

NEW SOURCES OF VEGETABLE OILS

The Department of Agriculture has demonstrated some new sources of production of edible oils in paying quanities.

Among these sources are tomato and sunflower seeds with yields of approximately 18% of oil by expression and 20% by solvent.

Okra seeds is suggested as a substitute for cotton seed oil.

What Does a Hospital Superintendent Expect of a Dietitian*

By LOUIS H. BURLINGHAM, M. D.

Superintendent, Barnes Hospital; Administrator, St. Louis Children's Hospital

TO go back to basic principles: What is expected of a hospital? It may be said to have as its functions (a) research, (b) the training of men and women in the practice of medicine, (c) the prevention of disease, (d) to act as a health center, (e) but its most important purpose is to care for the sick and injured.

What is expected of a superintendent? He is first of all responsible to his board of trustees and must see to it that all the problems of the hospital are presented to them in the fairest and most complete manner, second he must aid in all the activities of the hospital, doing all that he can within the physical and financial limits of the hospital, to cause it to properly fulfill its functions, and especial stress must be laid on seeing to it that the chief end-product of the hospital, which is a satisfied patient, results.

How does he accomplish this? First, by being fully abreast of modern thought and progress, in the fields of medicine, hospital management, social service and kindred subjects. Second, by being above all a co-ordinator.

To fulfill all the purposes of a hospital it is necessary that all the numerous factors that make up a hospital be working together without friction. In numberless ways he can aid the clinical, laboratory and nursing staffs, and he must have all the departments which are directly responsible to him, such as the housekeeping, store, bookkeeping, record, admitting, mechanical and dietetic departments working at the highest point of efficiency and not only that, but even more important is it that they be working together harmoniously. Practically all the departments in a hospital have a certain amount of dependence on each other, if they are co-operating the results are bound to be better than if one department is always trying to "get something" on another department.

Of the importance of the dietetic department there is no question. A well known surgeon has said that the dietary department has even more to do with the satisfaction of a patient than any other department not excepting the clinical and nursing departments. A hospital quite as much as an army travels on its stomach. Therefore the superintendent has the right to expect a great deal of the dietitian. (By dietitian I refer to the administrative dietitian.) He expects that she will have character, courage and an equable disposition and fairmindedness, all of these are necessary for handling the help well and meeting her problems. He expects an open mind, spirit of co-operation and loyalty—all of these are components of her personality. It goes without saying that the greater

*Read before the meeting of the American Dietetic Association, Indianapolis, October 16, 1923.

the background of culture and refinement she has, the better for her, for her position in her department, and in the hospital. She can hardly attain to her full measure of success unless she has a liking for executive and administrative work as well as an interest in scientific and research problems.

Training

As for training, she should have had college work with specializing in the sciences, dietetics, food values, and home economics, should have one degree, and if more than one so much the better; with the right kind of a personality there is no such thing as over-education. Nor should the practical side be omitted, she should know how to cook well if she is to retain the respect of her subordinates. Following her college work she should have had training as a pupil dietitian for a period of four to six months in a good hospital under a competent dietitian, and before she is ready for a position as dietitian in a large hospital, she should have served as an assistant in a large hospital or have been a successful dietitian in a small one. While it may be possible for a woman to be a successful dietitian without all this preparation, still it is to her advantage and to the advantage of her institution for her to have had it. Otherwise she learns by experience, which is a dear teacher both in energy for her, and dear in a material way for the institution that employs her. It is much better for her to learn all that she can from others, so that she may spend her time solving new problems, rather than working on those that have already been completed.

Health

On the physical side good health is essential. Her hours may be long, her work confining, and emergencies may arise, for instance, cooks are not always reliable and on occasions, though for only short periods, she should be able to step into the breach, and cook the midnight suppers when she is the only one available.

What should be the niche that the dietitian fills in the institution? Niche is used as a figure of speech for niche connotes a small compact place and the dietitian place is neither small nor compact.

In general her field should cover the preparation and serving of all food to all the personnel of the hospital, with all that that implies. To my mind this does not imply the purchase of food, for the field that the dietitian covers is already broad enough for one person. But as she is responsible for the end product, which is food, it is only fair that she should be consulted and that her opinion should have great weight whenever food supplies are being purchased. For instance, whenever canned goods are being tested, she should be present and take part. Whenever food supplies, whether meats, vegetables, or whatever they may be, are furnished her from the store room which are not up to the usual standard of the hospital, she should immediately report this, and in doing this she is seeing not only that justice is done herself, but also the institution. It may happen that the imperfection of some article may escape the attention of the storekeeper or butcher, and she be the first one to recognize it. It is justice to her because she cannot produce good food without good material—it is justice to the institution because the institution pays for supplies of good quality, and should receive them. Her opinion would have great weight also in the purchase of kitchen

utensils, equipment and supplies for the dining rooms, the latter, inasmuch as she is responsible for the service.

Responsibilities

The dietitian should be responsible for the preparation of all food. This includes food for the patients, including special diets, for the house staff, the nurses, and the employes. In preparing food for the patients the task of the dietitian is far from an easy one; in point of age she has to care for patients from the extremes of prematurity to senility; in point of social condition from the poorest to those in the very best of financial circumstances; the appetites vary from the voracious appetite of the healthy laborer who is suffering from a fracture, to the patient whose appetite is practically non-existent. In addition to the regular house diets she has to be in many cases responsible for the special diets for special conditions, as nephritis, gastric ulcer, diabetes and the diets for those who need building up. She also has to furnish food to doctors whose period of service may be only a year and to those who remain in the institution as intern, assistant resident, and resident for several years and to nurses whose regular period of training is in the neighborhood of three years. When one considers that simply eating in the same place for a considerable period of time has a bad effect on the appetite no matter what the place may be, it is easy to see how difficult it is to keep these individuals not only satisfied but pleased. Finally the help have to be fed and they too are not an easy problem, often a most difficult one. The ideal, of course, is 100% satisfaction but we know that such perfection can hardly be attained in human affairs. It is my opinion that dietitians in general, are to be congratulated on obtaining such satisfactory results, as they do. I wish also to commend them for their courage in the face of such persistent criticism. By this I do not mean that they ever are or should be well satisfied with what they have accomplished, but should always be striving for variety and a better product.

Serving

After the preparation of the food comes the serving. This involves getting the food as quickly as possible from the point where it was prepared into the mouth of the eater and I cannot refrain from repeating the dictum which is axiomatic so far as food is concerned "have your hots, hot and have your colds, cold." This means that the dietitian must see that the transportation is rapid, that the containers whether in conveyors or steam tables are kept hot, that the dishes are of the proper temperature, the silver and linen clean, and that those charged with the serving must be ready at the proper time, know what they must do, and do it promptly. It also means that the portions served to the patients must correspond with their appetites. It goes without saying that the service must be as tasteful as possible.

Costs

The next aid which the dietitian can give to the Hospital Superintendent is in the matter of costs. It is self-evident that food must be good, well prepared and well served, if it is to be satisfactory. A good dietitian, by proper management can serve better food for the same money or as good food for less money than can be offered by the hospital with no dietitian or with a poorly organized dietary department. The ways of ac-

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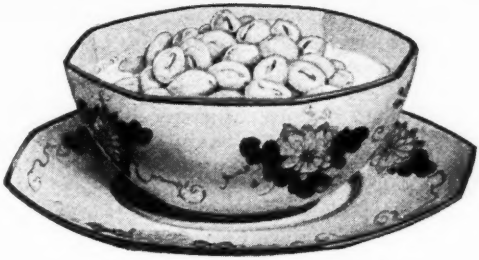
complishing this are: first, by carefully prepared menus for each of the chief divisions in the hospital, such as the private patients, ward patients, doctors, nurses, and help. These are prepared for a definite period in advance and care taken that the same meal never occurs on the same day of successive weeks, except perhaps, on Friday. This procedure is a very definite advantage to the dietitian as it enables her to arrange for properly balanced meals and for variety; even if the food is of good quality, well prepared and well served, I believe that it is impossible to have those who eat it satisfied, if they know in advance just what they will have for each meal on each day, it is also a very definite advantage to the store-keeper, for it enables him to make his purchases in accordance with a definite schedule. I know of a hospital where before the advent of an administrative dietitian, the superintendent, a cook, and the store-keeper used to get together in the ice-boxes each morning and from what they found there, make up the menu for the next twenty-four hours; the result was just what you would expect. The advent of a dietitian who prepared menus a week in advance resulted in meals which were well thought-out and well-balanced, and satisfactory together with a lowered cost per meal.

The second way of bringing this about is by taking care that the servings are not too large. I will comment on this statement simply by saying that this will result actually in more food being eaten and less wasted. It is not the food that is eaten, but the food that is wasted that hurts the feelings of the hospital administrator. Third, by watching carefully the waste. As a matter of fact this is one of the most important functions of the dietitian as it enables her to easily know what articles and what departments are over-serving and the likes and dislikes of patients. It may be inelegantly but nevertheless forcefully said that a dietitian can easily save her own salary from the garbage pails. To accomplish this she will, either personally or through her assistants —or pupils, supervise the serving of food in the serving rooms connected with the various dining rooms, and through co-operation with the nursing department, the serving of all food to all patients. It is sometimes more convenient to have the actual inspection of garbage under the house-keeping department, but she should be kept in regular and close touch with the results. Thus it may eventuate, that three departments, the dietary, nursing and house-keeping departments help in this one problem, but it is one of the most important of the hospital administrator's problems and the dietitian plays the most important role in it.

Cost Sheets

The fourth way is by keeping a cost sheet for each week. These can be collated into four or five week periods to correspond roughly to months and twelve of these in turn to correspond with the year. It has been found that if this work is carefully done that the results correspond to a surprising degree with the figures obtained in the book-keeping department, where the total cost of food supplies is divided by number of days of hospital care. It may not always be practicable for the dietitian herself to do this work but if it can be done by her it is a great advantage, as it enables her to keep her finger right on the pulse



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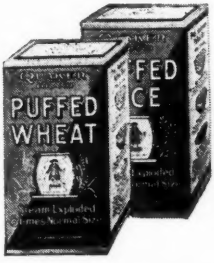

Quaker Puffed Wheat

Quaker Puffed Rice

ot the rate of expenditure. Forms can be devised which render this work not too burdensome and it is very excellent practice for the pupil dietitians to help to calculate them. Certain institutions have found it interesting and valuable to exchange regularly these cost sheets and when due allowance is made for differences in the location of the hospitals and in variations in the numbers of the various classes fed, it is quite remarkable how closely they correspond.

The Superintendent is entitled to have from the dietitian a well organized, well trained and harmonious organization. This is not easy, as tempers around a kitchen are apt to be short, but it is an ideal to be steadily worked for. In this respect the dietitian's life will not be monotonous, for her force may contain in addition to her assistants, and pupils, the chef, various cooks, dish and pot washers, waitresses, porters and cleaners, certainly a wide enough variety to keep things interesting.

On top of all the practical work is the teaching that the dietitian is expected to do. That the number of dietitians may keep pace in some degree with the demands for them as new institutions are steadily coming to realize the importance of the trained dietitian, and many dietitians are being called away to other fields, it is necessary that the well established dietitian train college graduates in the practical side of this work. This involves work in the kitchens, dining rooms, metabolism department, private pavilion kitchen, ward kitchens, preparation of feedings for children, purchasing of supplies, work in the dietary office where supplies are ordered, reports made and costs figured, and facts in teaching cookery to nurses.

Teaching

This leads us to the teaching of dietetics to nurses. The dietitian is responsible for the teaching of general dietetics and dietotherapy—theoretically and practically to the student nurse. She introduces the student nurse to food in a new light. Beginning with its scientific definition and classifications, covering its digestion, absorption, and metabolism in the normal body, to the caloric value of food and man's definite food requirement, the dietitian finally presents food in its application to abnormal conditions. Accompanying the theoretical training the student is also given practice in the preparation and service of simple foods at first and later of special diets. Through all of her training the nurse is under the supervision of the dietitian in her service of food to the patient.

After talking at this length about what the superintendent expects of the dietitian, it seems only fair to speak briefly of what the dietitian should expect of the hospital superintendent.

If of the proper caliber, she should not be considered a little better than a high class cook with certain specialized training for I believe that she is entitled to all the consideration due the head of a very vital part of the hospital organization. This means that with this responsibility she should be given a chance to use her own initiative in order that she may show results. On the other hand it means that she will avail herself of the privilege of frequent consultations with her chief on matters of policy, and on points of importance, as he can be of great help to her. There should always be a frank and full discussion of the subject in hand, and if she is unable to convince the superintendent that her point of

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view is correct, she should with a pleasant spirit follow the course he outlines to the best of her ability as if it were her own, provided that no moral issue is at stake. In addition to the points I have mentionel no one quality is of greater importance than loyalty: If the course above outlined is followed, there will never be any question of that.

In closing I wish to pay a tribute to the dietitians with whom I have been associated in my work as hospital administrator. I am only too glad to say that I have found them well-trained, their ability pronounced, their minds open and active, their courage good, and their loyalty unquestioned.

The Purity of Nitrous Oxide

By Ingo W. D. Hackh, San Francisco

Research Laboratory, Western Nitrous Oxide Co.

THE recognition of laughing gas as the ideal anesthetic, susceptible to any required variation in the hands of the expert surgeon, has many times been retarded by individual cylinders containing impure gas. Thus the user was not absolutely sure of the effects which a given cylinder would produce on the patient. It is likewise a phenomenon sometimes observed that an individual cylinder may give perfect results in the beginning, but, when only one-fifth to one-sixth of the compressed nitrous oxide is left, coughing and nausea are produced in the patient, causing the remainder to become unsuitable and even dangerous. It is the purpose of this paper to show the causes which give rise to the occasional unreliable results obtained from nitrous oxide, and thereby aid in the establishment of higher standards in its manufacture.

To begin with, the official tests prescribed by the Pharmacopoeia are not sufficiently delicate or to the point! Experience shows that the most common and the most dangerous impurities are not carbon dioxide or halongens for which official tests are prescribed, but the other oxides of nitrogen —especially the poisonous nitric oxide, for which no official test is provided. The formation of these other oxides during the manufacture of nitrous oxide by heating ammonium nitrate cannot be avoided. Traces are formed even with most careful operatons, hence the manufacturer must remove these traces from the gas and maintain a careful check of the finished product. By the official tests, this cannot be detected, for the amount of other oxides of nitrogen should not exceed 10 parts per million, by volume.

But, even when a day's manufacture of nitrous oxide is analyzed and found satisfactory, the manufacturer's responsibility does not end. It is a curious phenomenon that, when pure gas is filled indiscriminately into the steel cylinders for shipment, one or the other of these cylinders shows an increase in the content of other oxides of nitrogen. In other words, in filling one hundred cylinders with perfectly pure

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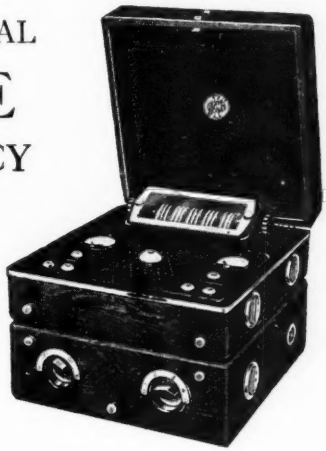

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gas there may be two to three containing impure gas. The reason for this phenomenon is found in the individual cylinder, namely, the frequency of its refilling. Because of the physical properties of nitrous oxide and the other oxides of nitrogen, they will evaporate or escape more readily from the cylinder, leaving the impurities behind, which naturally accumulate more and more in the cylinder, if it is not cleaned before each refilling.

This explains likewise why the last few gallons of gas drawn from a nearly empty cylinder may sometimes have a nitric-acid odor.

Fortunately, all of these manufacturing difficulties can be overcome and a perfectly pure gas produced. Likewise, it is possible for the surgeon to guard against impure gas by a few simple tests. Naturally, these tests are not to be looked upon as an analysis or as analytical tests; they are merely aids in detecting doubtful cylinders. It has been pointed out that the cleaning of cylinders plays an important role in removing the unavoidable small traces (less than 10 parts per million) of nitric oxide. The following test will indicate a clean cylinder:

Test for Clean Cylinder

Invert a cylinder and let stand for about one minute; when still in the inverted position, bring the nozzle about one-half foot from a filter-paper tacked on the wall. Open the valve rapidly so that a good stream of nitrous oxide spray issues and forms a small cone of nitrous oxide snow on the paper. Pure gas will give an absolutely white and colorless snow. Impure gas will leave a colored residue. If gas is contaminated with nitric oxide, the snow will be somewhat yellowish green. Oil from the compressor will show yellowish brown, while rust from the inside of the cylinder may be from brown to black. If the gas is not perfectly dry, the moisture will show on the paper. (The writer has found a cylinder of nitrous oxide from which he drew a wine glass of water, while frequently a slimy mud of oil and rust can be blasted from unclean cylinders.)

A further test is the odor. It should be the invariable practice of the anesthetist to inhale a few breaths of gas before giving it to the patient. Nitrous oxide has a very faint and pleasant odor, while nitric oxide will give an acid odor resembling, in higher concentration, the odor of chlorine or concentrated nitric acid. Unclean cylinders will have, especially toward the end, a more or less musty or stale odor, caused either by lubricating oil or by moisture.

Another safeguard for the careful operator is, to place a small wash bottle of potassium permanganate solution between the gas machine and the gas mask, at any convenient point. The solution should be often renewed as it is not permanent and will deteriorate in time.

If the nitrous oxide is dry and contains no determinable trace of moisture, the valve will not stop up, on opening, but will give a uniform and continuous stream of gas—provided the valve is not opened so far that a too rapid expansion of gas will liquefy the remaining gas to liquid nitrous oxide. The liquefaction of nitrous oxide hapens only in case the safety valve blows off or the valve is fully opened, and gas escapes unchecked into the atmosphere. In ordinary use with a gas machine, this will hardly ever happen and any freezing of the valve is due to moisture. To make an approximate test of this

(*Continued on page* 48)

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Notes and Queries

By EDWARD SWALLOW

This department is for the benefit of our readers. You are invited to send your problems and questions to Edward Swallow, care of The Hospital Buyer, Chicago.

TO REMOVE INK STAINS, AND HOW INK IS MADE — Registrar, Outpatient Department, Brooklyn, N. Y., asks if this department will give her some information as to the best way to remove ink stains from cotton and silk goods. "Will we give a recipe for a cheap and good ink, one not hard to make?" To remove ink stains from cotton, use a weak solution of either oxalic acid alone, or oxalic acid and sodium chloride, or a solution of oxalic acid with zinc dust. If neither of these will cause the stains to yield, use a solution of potassium permanganate, followed by sodium thiosulphate and citric acid. This last method is said to quickly remove all ink stains from cotton goods. Wash the material thoroughly after applying any of these stain removers. To remove ink stains from silk much depends upon the nature of the ink that caused the stain. Treat first with a weak solution of oxalic acid. If the ink mark contains an aniline dye, a second treatment with javelle water will generally remove it. The solutions should, of course, be weak. The following method answers well for ink stains upon paper, and might be tried upon the silk if the above should not be satisfactory: Place a few drops of strong solution of ammonia on the stain, then with a tuft of absorbent cotton soaked with dilute phosphoric acid, firmly press on the part. Repeat the process if necessary; the part is then washed in warm water, and finally dried in the sun. With both cotton and silk dyed goods it is best to proceed cautiously in applying any of the above stain removers. Try the effect upon a small portion of the materials first. If the dyes are not affected it is safe to go ahead. Regarding recipe for ink, the following recipe is said to make a cheap and excellent blue-black ink:

Blue-Black Ink

Tannic acid.....200 grains
Gallic acid.....50 grains
Protosulphate of iron.....1 oz.
Indigo carmine.....320 grains
Cloves, powdered.....5 grains
Distilled water.....1 pint

Dissolve the acids in the water, and add the iron salt. Filter through cotton, add the indigo carmine and cloves; stand for two days, then filter.

CEMENT FOR CLOSING LEAKS IN IRON PIPES.– Engineer, Illinois—The following formula is recommended for making a cement for closing leaks in iron pipes: 5 lbs. of coarsely powdered iron borings; 2 oz. of powdered salammoniac; 1 oz. of powdered surphur, and enough water to make a paste of a thick consistency. By leaving the sulphur out the cement will set more firmly, but will require a longer time. The cement is tamped tightly into the leak.

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DENTIFRICE FOR CHILDREN'S USE.—Social Service Worker, New York.—"As we make a practice of looking after the dental requirements of all children under our care, I thought it might be more economical and better in every way if we had our own tooth powder made up for them. Will you please supply a reliable formula?"

We certainly will, and here are two that can be thoroughly relied upon to keep the children's teeth clean and free from tartar, always provided they use their tooth powder twice a day, as every American should do.

Dentrifrice Powders

—1—

Camphor .....2 ozs.
Powdered myrrh.....2 ozs.
Powdered orris root.....1 oz.
Precipitated chalk.....32 ozs.
Oil of cassia
Oil of clove
Oil of peppermint
of each.....20 minims

The camphor is rubbed down in a mortar to a very fine powder, using a few drops (preferably) of chloroform for the purpose. Mix all ingredients thoroughly and pass twice through a fine sieve.

—2—

Precipitated chalk.....50 parts
Sodium chloride.....1 part
Powdered castile soap...1 part
Oil of cassia
Essence vanilla, of each.0.25 part
Mix thoroughly and sift.

THE STETHOSCOPE

It may interest readers of THE HOSPITAL BUYER who are more or less familiar with the doctor's stethoscope to learn that this instrument was conceived from a child's plaything. More than a hundred years ago, Laennec, one of France's medical pioneers, while watching a group of children playing in the gardens of the Louvre, noticed that they were transmitting sounds to each other along pieces of wood. Impressed with the idea of utilizing this method for listening to sounds in examining a patient's lungs, he went home, devised a tube from a roll of glued paper, and experimented with it in his ward at the Necker Hospital. Laennec gave to his invention the name by which the device is still known, deriving the word "stethoscope" from two Greek words, one meaning "the chest" and the other "to observe." The early stethoscopes produced by Laennec were constructed of a single wooden tube permitting the use by one ear only.

NITROUS OXIDE

(Continued from page 44)

possibility attach a glass tube to the valve and place it in a glass of water, then open the valve so that about three to four bubbles per second pass through the water. Let stand in this position and observe the regularity of the bubbles. There should be no irregularity in the number of gas bubbles passing through the water if the nitrous oxide is dry. Moist gas will gradually decrease the number of bubbles and finally stop entirely or bubble irregularly.

The few tests described give the gas user some indications of the purity of the nitrous oxide and call attention to the necessity of setting higher standards in gas manufacture. It is most desirable that the official tests be made more exacting, especially in regard to the dangerous nitric oxide.

It is the conviction of the writer that, with a pure nitrous oxide

to work with, the anesthetist has an ideal and reliable medium and that many, if not all, of the difficulties in gas administration are either directly or indirectly due to impure gas.

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Experiments on a large scale have proved that by wrapping apples in oiled paper instead of ordinary wrapping paper at additional cost of only two cents per box, the tendency of the applies to scald has been entirely stopped and the variation in the quality of the fruit after coming out of storage can be stopped and the quality kept uniform by the use of the oil paper wrappers.

AMERICAN COLLEGE OF SURGEONS MEETING

(*Continued from page 20*)

47% autopsies at various kinds of hospitals.

One valuable suggestion was made by a Superintendent who pointed out that greater co-operation should be maintained with the organization of undertakers. The undertaker often is made to spend his valuable time in waiting until an autopsy is performed. Naturally he becomes irritated and often tries to influence the family against permitting such an autopsy. If the hospital works with the undertaker by arriving at some definite understanding, one great obstacle is done away with.

Written permission for an autopsy should be obtained in every case. The hospital should not go ahead without such a written document. Legal entanglements may result if this point is overlooked.

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Hospital Architecture and the Department of Dietetics

By PERRY W. SWERN

Reprinted from Nov., 1923, issue Dietary Administration and Therapy

THE dietitian should come into every new building project at the very beginning—in fact, the importance of the dietary department must be preached night and day—even before a new building is talked about—and backed up with examples wherever possible.

The dietitian must be able to analyze, plan, visualize food travel and bring forth constructive suggestion. Just tearing to pieces is not enough. If some of our schools that are teaching dietetics would include a lesson or two in plan analysis, the time would be well spent.

THE hospital that is popular and talked about by the public, in most every case points to its food service with great pride. The opportunity of pleasing a patient's palate, while nursing him back to health, places in the hands of the dietary department a chance to make each patient a booster for the hospital. This is an old idea, and is the ambition of every dietitian, but to obtain such an ideal service is not easy, for there are a million or more places where the road is rough, and the many detours are enough to dampen the most resolute.

The viewpoints of the people who work in hospitals vary so much that you often find in the same institution ideas that are diametrically opposite to each other. The dietary department seems to be the most severely fought over battleground. The hospital superintendent has his ideas about the department, the doctors have theirs, the director of nurses has hers, and the dietitian usually gets the resulting compromise to do her work in, simply because hospital architecture has tried to satisfy all interests. No serious unbiased effort has ever been made to find out just how the department could augment nursing, deliver the desired nourishment to the patients in the most palatable form, and still keep within the budget.

Fundamentals of Procedure

Before taking sides, surely there are some common fundamentals of procedure in the operation of the dietary department upon which all interests can agree, with at least only minor reservations. Let us trace the movements of the food (the expendable material of the department) through its various stages. The provisions enter the back door in a hundred different forms —bottles, cans, boxes, barrels, carcasses, and so on. These deliveries, which may occur at every hour of the day, must be checked, inspected and placed in suitable storage space or refrigerators and entered on some sort of a perpetual inventory. This part of the procedure requires the functioning of an intelligent receiving department with proper liaisons with the dietitian, purchasing agent and superintendent. Putting the provisions under lock and key with precision and dispatch removes temptation.

With the perpetual inventory before them, the dietitian and

cook can easily make their requisitions for the daily supplies needed to fill the previously established menus, and the average daily demand for specials. These daily supplies are placed in the small refrigerators, provision cases, bins, lockers, or containers, located in the main kitchen, preparation room, bakery, or diet kitchen, convenient to the workers and out of sight as much as possible, to eliminate clutter, rehandling, and shrinkage.

The preparation, cooking and seasoning of the food is easy for those who know how — and at first thought might seem to be outside the realm of architecture. Motion study in a kitchen is very interesting, and it is surprising how many steps can be saved by proper grouping and arrangement of the equipment.

Food Transportation

Next, we come to the simple problem of getting this prepared food to the patients. And it is here that the real argument usually begins; some say by carts, others by set-up trays, and others by dividing the food into as many parts as there are nursing units, and sending it in bulk to diet kitchens, or probably better termed, "food serving rooms." The type of institution to be served must govern the method of distribution. Likewise the method of distribution plays a vital part in the type of plan selected.

There are some basic facts about transportation and production that should be rehearsed at this point; incidentally, they apply to the distribution of linen and household equipment as well.

1. Vertical transportation can be satisfactorily and economically accomplished mechanically.

2. Horizontal transportation requires the physical power and time of the workers to accom-

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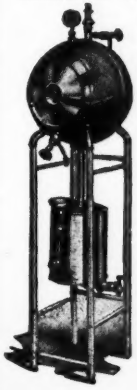

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pany the carriers. Dispatching employes to the four corners of an institution breaks down efficiency. The individual worker is not under the supervision of her superior, and thus wasted time and lost motions are hard to detect.

3. Rehandling from one container or carrier to another always creates shrinkage, consumes time and in the case of foods, tends to even the temperatures to that of the room.

4. Quantity production usually lowers the unit cost. The individual becomes more proficient with frequent repetition of the same duty.

5. Production with a regular flow of output lowers unit costs, and can be regulated to the most efficient speed.

Lost Motion

All of these facts have been proven repeatedly in industrial developments, and while a hospital has no similarity to a factory, there are departments in a hospital that can well take advice from the lessons learned where competition is keen and lost motion is known to eat up profits. With these ideas about transportation and production for a background, and a desire to promote to the highest degree the welfare of the patients, and comply with their whims, if at all possible, let us try to picture a physical arrangement that will be efficient and still retain individual service for the patients.

I think it is agreed that the meat, just as it comes from the roaster, all "sizzling" and "oozing," is in its tenderest condition; that vegetables as they are drawn out of the steam cooker are extremely tantalizing; that the mashed potatoes are at their height of fluffiness just as they leave the mixing machine; that the butter pats are at their best just as they drop from the press; that the bread is most willowy at the slicing machine; that salads depend upon the degree of freshness of the ingredients, and so on through all the foods, we find them at their best immediately upon completion.

Now if all this preparation and cooking could come to a finish at the same time, and the portions immediately placed on the dishes and in front of the patients, without any interval of time elapsing, or necessity of rehandling, an ideal condition would exist as far as the success of food preparation is concerned. Such a goal cannot be obtained, however, for food must go to almost every nook and corner of the building.

Food Service Radius

The average distance that the prepared food has to travel before it reaches the patients has been dubbed the "food service radius." The length of this "food service radius" is a direct measure of plan efficiency and vital to the operation of the dietary department.

Some of the factors that are important in keeping this "food service radius" small are:

1. Concentration of patients into compact nursing units.

2. Establishing service stations around the kitchen, with complete set-up and clean-up trays under the supervision of the dietitian.

3. An arrangement of equipment and a system in the serving stations that follows a progressive scheme of production.

4. The executing of all work of the same kind in as few places as possible.

5. Providing means of vertical transportation that do not cross or conflict with the work of other departments, so that the dietary

department can function almost regardless of any crisis that may drop in on a hospital.

It does not matter much whether you are planning a fifty bed hospital or an institution of a thousand or more beds, the basic principles of "Measured Circulation" are the same and must be followed if a *small* "Food Service Radius" is expected.

The Main Kitchen

A main kitchen where all general preparation of supplies, bulk cooking and baking is done, must be set up for every hospital; whether this main kitchen can be a central kitchen or not depends on the size of the institution, existing buildings, physical properties of the site, and many other features. Please note the distinction between main kitchen and central kitchen. A kitchen that is not located so that the food service radius is somewhere near equal in all directions should not be called a central kitchen. Usually in all hospitals of less than 300 beds the kitchen can be located centrally and can thus be rightfully called a central kitchen, around which can be located the various serving stations, radiating from the kitchen like the spokes of a wheel, and these service stations in turn can be placed so that their food lifts can be unloaded close to the patients. The nearer these lines of food travel are to being straight, and the less corners there are to turn, the shorter the "food service radius."

We are so in the habit, when planning buildings, of slicing them up horizontally and thinking of each floor as a unit that we lose sight of the fact that perhaps we could make the slices vertical for some departments of hospital service and still have the horizontal divisions for others.

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This is virtually what is done with the dietary department. The food radiates in bulk from the central kitchen to the serving stations where it is divided into tray service and dispatched up the lifts to the patients on each floor over the vicinity of the serving station. In other words the patients on any one floor receive trays from all the serving stations and the long carrying down corridors is supplanted by vertical mechanical transportation. The serving stations are really nothing more than the old type floor diet kitchens, taken off of the floors, revamped and placed around the central kitchen and under the group of patients that they serve. Such an arrangement has many advantages.

1. It materially shortens the food service radius.

2. It allows the light and cheery contents of the building on the upper floors to be used for patients.

3. It concentrates all work with foods and dishes (clean and dirty) in one general department, which promotes the efficiency of workers, creates "esprit de corps" and conserves supplies.

4. It simplifies the floor nursing and gives the dietitian and her staff complete control of the foods that go to the patients.

5. Special trays or feedings can be sent to any patient at all hours and are not confined to one floor or portion of a building —an item which increases the bed flexibility.

Naturally there are points which must be guarded against:

1. The time interval between the completion of a tray and when it reaches the patient must be small, and the dispatching of trays to the floors must be rotated to keep the work on the floors from bunching.

2. The dietitian and her staff carry the whole responsibility and must keep up a personal contact with the patients, and the trays must bear this out. There will be no chance to blame the floor nurse.

3. Such a procedure must not be allowed to become so mechanical as to lose its teaching value to the pupil nurses, and these girls will have to be tolerated in the various service stations, while they are learning (under real supervision) how to prepare foods and set up attractive trays.

In larger institutions with a group of buildings, the main kitchen may or may not be near the center of the group and the food service radius will be increased by the length of these connecting corridors, but after the food reaches each building, there is nothing to hinder dispensing it from ground floor serving stations similar to a smaller hospital.

The Dietary Department

The Dietary Department affects hospital architecture more than any one other department; it establishes the back-bone of the plan and dictates most strongly the location of all the transportation units—it handles by far the most supplies measured by weight, volume, pieces or frequency. The dietary department can no longer function efficiently as detached units on each floor operated as a part of the nursing. The advancements in dietetics and the increasing interest in diets by the medical profession are forcing dietary departments to function as service departments at the "beck and call" of the doctors. And to clinch the thing, along comes old Mr. "High Costs" who forces conservation.

SOUTHERN HOSPITAL NOTES

A GREAT memorial hospital for the exclusive treatment of women and children, to be established in some Georgia county designated by a board of trustees, has just been provided for in the will of the late Mrs. Cora B. Williams, president of the Georgia, Florida and Alabama railroad, who died March 22, at her home in Atlanta, Ga.

With the exception of a $10,000 fund for North Carolina students in the University of Virginia, and several bequests ranging from $5,000 to $7,500, the entire estate was left to the proposed hospital.

While the will, which has just been probated, did not divulge the value of the estate, it was stated that the amount involved providing for the building and operation of the hospital would reach several hundred thousand dollars.

John Lord Nesbit, named as executor in the will, was authorized to appoint a board of trustees which will control the establishment and management of the new hospital.

According to Mrs. Williams' will, it had been the intention of her husband to use his fortune for the benefit of mankind, and it was his wish as well as her own that the money should be devoted to that purpose.

Accordingly a hospital, to be known as the Jesse Parker Williams Memorial Hospital, was selected and the bulk of the estate left to it.

While the location and plans have not yet been decided upon, it is understood that this will be one of the largest and best equipped hospitals in the entire south when it is completed.

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The American Laundry Machinery Company manufactures a complete line of laundry machinery. It maintains a corps of engineers who are specialists in planning hospital and institutional laundries.

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The American Laundry Machinery Company,
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CANADIAN FACTORY: The Canadian Laundry Machinery Co., Ltd.,
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(Continued from page 18)

collected and compiled and published in the annual reports of the Sanitary Bureau, which have since appeared regularly. The statistics for which investigations are now being made relating to infectious diseases, hydrophobia, medical practitioners, dental surgeons, pharmacists, patients among factory hands, sufferers from poisoning, health examination of licensed prostitutes, examination of milk, foods, slaughterhouses, slaughtered cattle, etc.

Further method of investigation was determined upon with respect to insane persons in public and private hospitals and with respect to patients admitted into leper asylums.

Investigations in social statistics are also being carried on in regard to acute and chronic infectious diseases, and mortality of infants at the breast and young children. There are signs of progress and improvement everywhere, and the country is rapidly coming to the fore.

THE HOSPITAL SITUATION IN JAPAN

Hospitals Destroyed—St. Luke's Hospital Destroyed — General Extent of Damage from Earthquake — Gifts of Hospital Equipment and Supplies from American Red Cross and Japanese Red Cross.

GREATER Tokyo has a population of approximately four and one-half millions. Before the earthquake and fire on Sept. 1st, the town had only 236 hospitals, with a total of a little over 15,000 beds. From this it will be seen that the actual number of hospital beds is much less than the proportion in the large American and European cities. An estimate made two months ago gives the total number of houses destroyed as 224,560, of which 137 were hospitals of over 25 beds. The remaining 99 hospitals, with some 8,500 beds, will give an idea of what the earthquake meant in loss of hospitals to the city.

Japanese Planning and Organization of Hospitals

Before the recent earthquake there were not more than four hospitals with more than 200 beds in the city of Tokyo. The majority of Japanese hospitals correspond somewhat to our nursing homes, and are conducted either by physicians as a private clinic or are connected indirectly with some larger institution. As the city authorities do not permit buildings for hospitals to exceed three stories in height, practically all of these hospitals are two-story stucco buildings. It is probably largely due to this that the percentage of deaths from the earthquake and subsequent fire was lower than would have been the case if higher buildings of the American type had been in general use. In all cases credit must be given to the quick action of the staff of the numerous hospitals throughout Tokyo for the record of the number of patients saved, considering the rapidity with which the fire spread and the suddenness of the first earthquake shock. One of the largest private hospitals in the city, which has been conducted for nearly a century by the Sato family, who have been physicians for generations, was entirely burned. Many parts of the University Hospital, a building of the German pavilion type, were practically destroyed, and the laboratories in particular seriously damaged. Some twenty hospitals located around the University of Tokyo within a mile radius were completely wiped out by the fire. The

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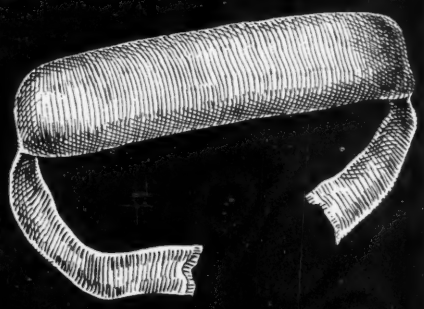

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Takagi hospital in Shiba was entirely burned.

St. Luke's Hospital Destroyed

Dr. S., a Japanese assistant physician on the staff of the St. Lukes Hospital who had witnessed the first shock, gave me a description of the happenings on the first day. The St. Luke's Hospital was a three-story building, located in the center of the most thickly populated district of the city, protected on one side by the Sumida river. All that I could see of it now was a mass of ruins which remind of the pictures at Ypres, Poelkapelle, etc., on the Flanders front. The hospital was exceptionally fortunate in saving all of the patients and the whole staff, including the servants. At the first shake the stairways of the building were immediately twisted and broken and rendered unfit for use. In some places the floors sagged almost at right angles, while the walls bulged from the floors, leaving a gap of several feet. With the prompt assistance of all doctors and some forty Japanese nurses who were on duty at the time, the patients were hurried out of the building into the street in less than fifteen minutes. The building was abandoned and the patients taken across the Sumida river to an open park-like piece of property which belonged to the hospital. The violence of the first shake was so severe that people in the streets staggered and literally fell. It was not till the afternoon that the Tsukiji region, where the hospital stood, was threatened with fire. Till then in the course of the morning thousands of refuges, thinking the neighborhood of the hospital perfectly safe, came pouring in from all parts of the district. The crowds who came to seek refuge brought with them quantities of baggage in carts and automobiles. These piles of baggage caught fire from the Hongwanji Temple about three blocks away, the first large building in the immediate district to be destroyed. From this center the fire had spread till, late in the evening, the dormitories, the school for nurses as well as the main building of the St. Luke's Hospital were utterly consumed by the flames. The heat was so terrific that numbers jumped into the river and onto passing boats, many of which later caught fire and burned to the water's edge. Many lost their lives even in the small gardens where they had taken refuge, thinking they were safe.

As to the entire extent of the damage, practically the whole of Tokyo was wiped out. For nine miles along the shore of Tokyo Bay and on both sides of the Sumida river, which bisects the town, there is one picture of complete destruction. The devastated area averages over two miles in width, and included six of the most densely populated sections of the town. Almost all of the wholesale and retail districts of Tokyo on the western side of the river, including many large private residences, as well as the district of Honjo on the eastern side, where the poorer classes lived, were completely wiped out.

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INCREASING UPWARD TENDENCY IN WAGES IN THE BUILDING TRADES

The American Contractor says wage scales during March and effective April 1st showed a strong tendency to mount to still higher levels. Sixty-two raises in separate crafts were reported from fourteen cities during March. The cuts were reported from four cities during the same period.

This is a distinct upward movement compared with the increases of the previous month during which 26 raises occurred. During March, 1923, there were 85 raises and 5 cuts.

Since the upward trend commenced in May, 1922, 1,021 crafts in individual cities have secured raises while eighty-one cuts have gone into effect.

Present indications are that wages will continue to rise slightly during the next few months, but the sudden jump which occurred during the same period last year may not occur.

At present the demand for building continues firm. The volume of building permits and contracts awarded is breaking all records. Indications are that the continuances of this gigantic building program depends entirely on the attitude of labor during the next three months.

There was no indication during the month of March that labor was taking steps to protect the life of the industry. Yet it is hard to believe that far-sighted union men will deliberately seek to strangle the industry in which they work when the industry is paying them the highest wage ever paid in any industry, and is affording them working conditions which are equitable to say the least.

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THE OPIUM CURSE AMONG THE CHINESE

By Edward Ahlswede

Special to THE HOSPITAL BUYER

I HAVE just spent some days in Hongkong looking into opium retreats and making inquiries in well informed quarters. As the Chinese opium smoker does not go out into the public street and make a noise and possibly fight as is often seen with sailors after drinking—the newcomer is at the mercy of externals and needs the guidance of an experienced resident until he learns the meaning of what he sees.

The typical opium joint of Hongkong is quiet and clean. The guests recline on couches and smoke. They lie quietly on their mats dreaming, and then go home peacefully. This is the first general and outstanding impression one gets.

The drug and the method of cultivating the poppy plant was introduced into China as early as the thirteenth century by the Arabs. It has cursed China ever since, and held the nation down and asleep even in recent years. It is estimated by the year 1900 that 25,000,000 men and women in China were opium habitues. The edicts forbidding the use of opium and the raising of the poppy plant made by the Queen Dowager about 1907, and later by the leaders of the Republic of China, which seemed so promising a decade or more ago, have come to be largely disregarded. This has resulted because England has continued to make the prohibition impossible. Great Britain agreed in 1907 that Indian opium should be withdrawn, and in 1913 she stopped the shipping of opium from India to China. This, however, did not change the fact that she continued the government monopoly of making opium in India, thus making it possible for individuals to purchase it and smuggle it into China. While Japan acts to some extent as a go-between in the opium traffic in China, the press frequently accuses Japan of directly encouraging the opium vice in China—a charge which no one can substantiate and few care to deny. Japan herself does not use opium. She has millions of Chinese under her flag, many of these in the island paradise of Formosa.

Japan does not encourage the use of opium. On the contrary she forbids young people acquiring the habit and thus hopes that in time, as the old ones die off, the habit will gradually expire.

But no country can entirely suppress opium smuggling any more than America has been able to prevent its people from procuring strong drink.

The opium produced annually in India—several thousands of tons—is a monopoly by the British government. To stimulate the production the government advances money free of interest to those who wish to undertake the growing of poppy. The amount of opium manufactured in India has been increased by nearly 50 per cent in ten years.

England, by her example, is also encouraging China, Turkey and Persia, which are the other three countries in which the growing of poppy is lucrative, to extend the production of opium.

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CHLORAZENE is unequaled for general use. As a wound antiseptic, for douching, for routine hand cleaning, for disinfecting instruments and sundry articles used in the operating room, sick room and office, it is the practical antiseptic for hospital and institutional use.

Sample package sent on request. Bottles of 100, 500 or 1,000 procurable at your drug store or direct.

✣ ✣ ✣

Chlorazene Powder, Chlorazene Surgical Cream and Aromatic Chlorazene Powder are also stocked by most druggists or may be obtained direct.

The Abbott LABORATORIES
CHICAGO
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ELECTRICITY FOR COOKING

(*Continued from page 29*)

Automatic egg boilers regulating the boiling time from one half to six minutes, have a wattage of 2 K W for 2 to 3 baskets.

Warming closets 20x30x20 consume about 1,760 watts. After the apparatus is once warmed up the low heat holds it and a pilot light indicates whether the current is on or off.

The electrically heated carving table will have a wattage of 6 K W for each six feet of table.

The broilers consume 5 K W for the 24-inch, and 7 K W for the 30-inch.

Electric frying kettles consume as follows:

14x 7 in. minimum ¾ maximum 3 K W
18x 8 in. minimum 1¼ maximum 5 K W
20x10 in. minimum 1¾ maximum 7 K W

Stock kettles.—The most sanitary and highest type are constructed of heavy monel metal thoroughly insulated to retain the heat. The current consumed is —10 Gal. capacity 4½ K W, 20 Gal. 6 K W, and 30 Gal. 9 K W—maximum. As after the contents are brought to boiling it takes only a small current to maintain the heat. The total consumption is much less than that indicated by the maximum given. Where steam is available, however, steam stockpots are the best.

Dishwashers carry a range of from 3 to 9 K W to do the heating of the water, and are also better heated by steam when available.

The other labor saving machines, electrically driven, will not be enumerated as the current used by them does not come under the head of fuel.

Sleep that knits up the raveled sleeve of care,
The death of each day's life,
Sore labor's bath,
And balm of hurt minds,
Great nature's second course,
Chief nourisher in life's feast.

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WH. SPRINGER is the inventor of a practical waterproofing fabric process known as the "Hermetite," which is meeting with success in the hospital field.

By this process sheeting is made absolutely waterproof; it is said to be far more durable than rubberized cloth resisting boiling water, ether, phenol, chloroform, grease, oil and most acids and alkalies in common use.

The first product put out under license with the Hermetite patents was the Terry Waterproof Hospital Sheeting. This sheeting, unlike rubber sheeting, can be sterilized in boiling water and then ironed out, without losing its waterproof qualities. It is soft and pliable and will not crack or peel, which renders it most acceptable for hospital and sick room use.

In addition to hospital sheeting the Hermetite Process is applied to a number of other fabrics in white and plain shades and printed designs for kitchen coverings, shower bath curtains, crib sheets, furniture covers, window shades and other uses.

The Hermetite Chemical Corporation, of 250 W. 57th Street, New York City, manufacture exclusively under license waterproof fabrics and paper under this process. The Consolidated Textile Company, of New York, have the exclusive right to apply this Hermetite process to cotton fabrics. Converse & Co., of 88 Worth Street and 325 Broadway, New York, are selling divisions of the Consolidated Textile Co.

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SPECIAL ATTENTION—I furnish all kinds of Nurses, Pupils, Technicians, Physicians, Attendants, Internes—in fact ALL kinds of help for Institutions. Also furnish positions to all kinds of Nurses, Physicians and Institutional employees. Also sell and furnish physicians' practices, locations, partnerships, positions, etc. Established 1904. Gilt edge references. Special plans. F. V. Kniest, R. P., Peters Tr. Bldg., Omaha, Neb.

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The berries are sold at auction at the shipping points by the growers to the shippers who pack and ship them.

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Look forward and not back,
Look out and not in—and
Lend a hand."

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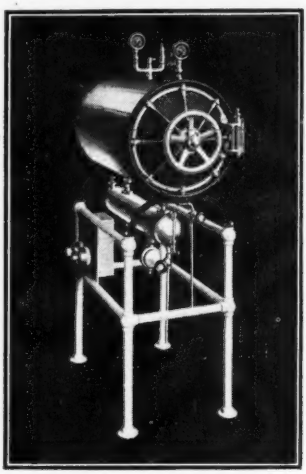

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¶ IT IS NOT SUFFICIENT to purchase just any sort of gas-oxygen machine, but the instrument should be selected which properly meets the requirements for which it is to be used. Cheap appliances are not often economical in their operation and rarely have definite utility. A few more dollars paid for a McKesson is returned many times in economical operation and the satisfaction enjoyed during its long life of usefulness.

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Price Reduced One-Third
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Effective June 9th

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U-10— 50 Units (10 units per c.c.) from $ .90 to $ .60
U-20—100 Units (20 units per c.c.) from $1.50 to $1.00
U-40—200 Units (40 units per c.c.) from $2.80 to $1.80

SAVINGS IN COST SHARED WITH CONSUMER

In January, 1923, when we first began making a charge for Iletin the price was five cents per unit. Since that time the need for costly experimental work has diminished. Substantial savings have also been effected by using larger lots of glands and by increasing the yields as a result of improved methods of manufacture.

These savings have been passed on consistently to our customers in the form of price reductions. With the last reduction, the price of a unit Iletin (Insulin, Lilly) is only about one-fifth the original price.

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The Marvel of the Shell-Shocked

The Danger of Ethylene Mixtures

Duties of The Hospital Dietitian

The Doctor's Viewpoint of The Layman's Diet

Stamping Out Yellow Fever in India

JULY, 1924

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